C&RCFD 044 REV 07/04

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION

CHILD & RESIDENTIAL
CARE FACILITIES DIVISION

Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:

825 North Capitol
Street, NE
Second Floor
Washington, DC 20002

PROVIDER HEALTH CERTIFICATE

Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Telephone No: _____

Address: _____

I have examined the above-named person and certify that he/she is:

- Free from disease in communicable form.
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ PPD ☐ Chest X-Ray

Date: _____ Result: _____ _____
Signature of Recorder

Other: _____

_____

_____

_____ MD/NP Date of Examination: _____
Signature of Examining Physician/Nurse Practitioner

_____ Telephone No.: _____
Address (Area Code)

PLEASE RETAIN A COPY FOR YOUR RECORDS